Getting a Grip on My Depression: How Latina Adolescents Experience, Self-Manage, and Seek Treatment for Depressive Symptoms

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Abstract

Latina (female) adolescents are more likely to experience depressive symptoms and less likely to receive mental health services than their non-Latina white peers. We aimed to develop a framework that explains how Latina adolescents experience, self-manage, and seek treatment for depressive symptoms. Latina young women (n=25; mean age=16.8) who experienced depressive symptoms during adolescence were recruited from clinical and community settings and interviewed about experiences with depressive symptoms. The framework was developed using constructivist grounded theory methods. Participants experienced a psychosocial problem that we labeled *Being Overburdened and Becoming Depressed*. They responded to this problem through a five-phase psychosocial process that we labeled *Getting a Grip on My Depression*. Family members, peer groups, and mainstream authorities were influential in how participants experienced these phases. Future research should further develop this framework in diverse samples of Latino/a youth. Clinicians can use this framework in discussions with Latina adolescents about depressive symptoms.

Introduction

Latina (female) adolescents experience higher rates of depressive symptoms than non-Latina white and non-Latina black[i] adolescent girls in the United States. According to the Centers for Disease Control and Prevention (2018), 46.8% of Latina adolescents reported feeling sad and hopeless on a daily basis, in comparison to 38.2% of non-Latina white adolescent girls and 40.7% of non-Latina black adolescent girls. These high rates of depressive symptoms are associated with serious health consequences, in particular suicidality (Zayas, Lester, Cabassa, & Fortuna, 2005). Substance use and rule-breaking behavior are also associated with depressive symptoms in Latina adolescents (Cano et al., 2015).

Universal and cultural stressors contribute to the high rate of depressive symptoms for Latina adolescents. Universal stressors are those that impact all adolescents, regardless of race or ethnicity (Stein, Gonzalez, & Huq, 2012), such as general family conflict and peer victimization (Kelly et al., 2016). Cultural stressors are negative events that are experienced due to belonging to a particular ethnic group (Stein et al., 2012). Discrimination, family conflict over cultural values, perceived lack of opportunity in the US, and immigration difficulties are cultural stressors associated with depressive symptoms for both male and female Latino/a youth (McCord, Draucker, & Bigatti, 2018). Additionally, studies have demonstrated that Latina young women in particular experience increased depressive symptoms related to the stress that results from discrepancies between parents' and their daughters' beliefs about traditional gender roles for women (Céspedes & Huey, 2008; Piña-Watson, Castillo, Ojeda, & Rodriguez, 2013).

Despite having high rates of depressive symptoms, Latina adolescents are less likely to receive treatment for depression than their white peers. According to the Substance Abuse and Mental Health Services Administration (2017), 31% of Latina adolescents experiencing Major

Depressive Disorder (MDD) in 2016 received mental health treatment for depression, in contrast to 41% of non-Latina white adolescent girls. Both male and female Latino/a adolescents are also more likely to see a primary care provider than a formal mental health provider when they seek mental health treatment (Garland et al., 2005) and less likely to be prescribed antidepressants (Cummings & Druss, 2011; Kirby, Hudson, & Miller, 2010) than non-Latina white adolescents. Although studies have shown that Latina adolescents experience disparities in receiving depression treatment, little has been done to develop strategies that will increase the use of mental health service use in this population (Davidson, Soltis, Albia, de Arellano, & Ruggiero, 2015).

Evidence-based treatments exist to treat adolescent depression, such as cognitive behavioral therapy, interpersonal psychotherapy, and antidepressant medications (Lewandowski et al., 2013), but few of these treatments have been modified to address the experiences of Latina adolescents (Hooper, Mier-Chairez, Mugoya, & Arellano, 2016). Because Latina adolescents live within a unique sociocultural environment that affects the development of mental health problems and how they seek and use mental health services (Davidson et al., 2015), mental health services should be adapted to meet their unique needs (Chu, Leino, Pflum, & Sue, 2016). Latina adolescents needing mental health services may not seek them or be engaged in treatment if services do not address their unique experiences (Chu et al., 2016).

A few qualitative studies have addressed perceptions of depression (Fornos et al., 2005; Garcia & Lindgren, 2009) and the etiology of depressive symptoms (Lopez-Morales, 2008) among Latino/a adolescents, and more recently, disclosure and mental health service utilization patterns among both Latino/a and non-Latino/a black adolescents with depression have been described (Cordel, Anker, & Bansa, 2016; Schneider, 2017). However, no studies have examined

how self-management or treatment seeking for depressive symptoms unfold over time from the perspective of Latina adolescents specifically.

In order to develop culturally sensitive strategies to prevent, identify, and treat depressive symptoms in this population, it is necessary to understand how depressive symptoms, self-management, and treatment seeking unfold over time from the perspective of Latina adolescents. The purpose of this study was to develop a framework that describes how Latina adolescents experience, self-manage, and seek treatment for depressive symptoms.

Methods

Design

Constructivist grounded theory methods (Charmaz, 2014) were used to develop a framework that reflects the experience of Latina adolescents suffering from depressive symptoms. Grounded theory methods include the systematic, yet flexible, collection and analysis of qualitative data with the goal of developing a framework that is grounded in the data (Glaser & Strauss, 1967). Under a constructivist approach, it is assumed that the researcher and participants bring their past experiences to data collection and construct reality together (Charmaz, 2014). The resulting grounded theory framework explains psychosocial processes that change over time and situates those processes in a specific social context (Glaser & Strauss, 1967). Grounded theory methods were chosen to guide the study because the unfolding of depressive symptoms is a psychosocial process and the Latino/a culture serves as the context for Latina adolescents' experiences of depressive symptoms.

Sample and Setting

The participants in this study were young Latinas who were currently experiencing depressive symptoms or had depressive symptoms at some point during their adolescent years.

The team wished to obtain narratives from young Latinas who had experienced a broad range of depressive symptoms as adolescents, had or had not experienced formal mental health treatment, and had or had not told adults about their depressive symptoms. Participants were therefore recruited purposively from two age groups and from several settings (Charmaz, 2014). Latina adolescents (ages 13 to 17) were included in the sample to discuss their contemporaneous experiences with depressive symptoms, and Latina young adults (ages 18 to 20) were included to discuss their experiences with depressive symptoms retrospectively, with the assumption that they would be able to discuss their adolescent experiences with perspective. The sample was recruited from primary care and community settings in a large, urban city in the Midwest US. Ten percent of the city population is composed of Latino/a individuals, the majority of whom are of white race and Mexican heritage (United States Census Bureau, 2017). Eligible participants were female, self-identified as Latina, spoke English fluently, and reported depressive symptoms during their adolescent years. In addition, participants from the primary care setting had a documented clinical history with depression. Participants were excluded if they were currently experiencing a mental health crisis or imminent thoughts of self-harm.

Participants from the community were recruited by placing study fliers in venues that young Latinas were likely to gather (e.g. libraries, churches, a local college campus, and coffee shops). The study was also announced at local programs serving Latina adolescents. The fliers indicated that the team would like to interview Latinas between the ages of 13 and 21 who had experienced depressive symptoms during adolescence, displayed a list of depressive symptoms in everyday language, and included a number to contact the Dr. Stafford. Other participants were recruited from a local primary care clinic serving a large Latino/a population. Dr. Stafford worked with providers at the clinic to identify Latina young women with a clinical history of

depression who may be eligible for the study. Providers introduced the study to potential participants, and if interested, invited Dr. Stafford to describe the study in further detail.

Participants who saw the flier in the community and were interested called a toll-free phone number. Upon calling this number, they were interviewed for eligibility by Dr. Stafford. A distress screening guide was used prior to enrolling participants in the study (Draucker, Martsolf, & Poole, 2009). The guide directed Dr. Stafford to ask the caller if they were having any imminent thoughts of self-harm or currently experiencing a mental health crisis and provided follow up actions for the screener based on the level of risk (i.e., referring to a mental health provider, calling to check on the caller the next day, contacting the local authorities for transport to the emergency department; Draucker et al., 2009). If potential participants from the clinic were interested, Dr. Stafford met with them during their visit, described the study, and verified eligibility. Verbal adolescent assent and parental consent were obtained for adolescent participants, and informed consent was obtained from young adult participants. All study procedures were approved by the Indiana University Institutional Review Board (Protocol #1702476593).

Data Collection

Participants first completed a demographic form with questions about age, generational status, and countries of heritage. Additional data were collected by semi-structured interviews. The interviews were scheduled in public locations with private rooms within participants' local communities. Interviews were driven by a guide and conducted in English by Allison Stafford. Interviews began with questions related to the participants' overall experiences with their depressive symptoms and transitioned to focused questions to collect further data related to the aims of the study. Examples of interview questions included: "Tell me about what was going on

in your life the first time you experienced depressive symptoms"; "What was something you did to make yourself feel better during that time?" and "Tell me about who you talked to about your depressive symptoms during that time." If a participant were to become distressed or if safety concerns arose during the interview, a distress protocol was available to guide the response of the interviewer (Draucker et al., 2009). A distress protocol similar to the one described above was used to guide the actions of the interviewer if a participant indicated in the interview that they were experiencing thoughts of self-harm or acute distress. The interviews were audio-recorded and transcribed verbatim.

Data Analysis

Analytic coding procedures as described by Charmaz (2014) and consistent with grounded theory were used on the interview narratives. The first stage of coding is initial coding, which is the process of examining small segments of data and expressing them as actions in the gerund verb tense (Charmaz, 2014). Dr. Stafford performed this coding on the transcripts, and the initial codes were verified by Dr. Draucker. The next step, focused coding, involved comparing initial codes between transcripts to reveal patterns in the data and sorting these codes into categories based on identified patterns (Charmaz, 2014). During focused coding, Dr. Stafford grouped initial codes together into tables in Microsoft Word™. During axial coding, the properties and attributes of the emerging categories were generated (Strauss & Corbin, 1998) without applying a predetermined organizing scheme (Charmaz, 2014). Throughout the process of axial coding, Dr. Stafford wrote memos to document thoughts on the definitions and properties of the emerging categories. She also engaged in frequent discussions with Dr. Draucker who provided feedback on both focused and axial coding. Constant comparative methods were also used to compare new interview data with previously collected data to identify

similarities and differences (Charmaz, 2014). The final level of coding, theoretical coding, involved identifying the relationships between categories so that they could be placed into a framework; we allowed the framework to emerge from the data without applying a predetermined framework or theoretical codes (Charmaz, 2014). Once categories were well established, Dr. Stafford returned to the transcripts to determine how categories related to each other across participants. Tables in Microsoft Word™ were used to track how each participant moved through the categories over time. The entire research team was involved in discussion during theoretical coding, so the final framework reflected team consensus.

To maintain trustworthiness and credibility, we implemented several strategies. First, all team members were involved in the data analysis process so that the final product of the study was consistent with the data and reflected consensus among the entire team (Charmaz, 2005). Theoretical memos were also used to keep an audit trail of thoughts and analytic decisions that were made throughout the coding process (Charmaz, 2005). While traditional member checking of the findings was not completed, theoretical sampling was practiced by questioning participants later in the interviewing process about categories that were emerging based on interviews from early participants to determine properties and relevance of categories (Charmaz, 2005). Several members of the research team had worked with Latina young women in community and clinical settings, so they were also able to weigh in on the practical utility and resonance of the framework (Charmaz, 2005).

To promote rigor throughout research process, we also practiced reflexivity by examining our motivations for conducting the research, biases and assumptions that we brought to the research process, power differentials between the researchers and the research participants, and how participants were able to speak to the analytical process (Rae & Green, 2016). We

recognized assumptions we brought to data collection and analysis through team discussion and journaling after each participant interview. We attempted to challenge our assumptions by orienting ourselves to the research using a constructivist perspective and recognizing that Latina adolescents were the experts in their culture and in their experiences with depressive symptoms. We addressed power differentials by explaining to participants, prior to each interview, the purpose of the study and how the researchers came to be interested in the topic. After each interview, the interviewer documented feelings about the interview and how the participants appeared to respond to the interviewer. Most participants did not speak about their feelings being interviewed by a non-Latina white woman who was an outsider to the culture. Some expressed at the end of the interview that the interviewer asked them "good" questions and that they enjoyed the interview. Through theoretical sampling, participants were also able to assist in the analytical process by giving their opinion on if emerging categories were relevant to their experiences (Charmaz, 2014).

Results

Twenty-five Latina young women participated in the study. On average, participants were 16.8 years old (SD=2.4) with a range from 13-20 years old. Eight participants were recruited from a primary care clinic, and 17 were recruited from the community. Eight participants were first-generation immigrants or born on the island of Puerto Rico. Of these first-generation individuals, ethnicities were as follows: Mexican (n=5), Puerto Rican (n=2), Cuban (n=1), and Honduran (n=1). First-generation participants had lived an average of 10 years in the US. Fifteen participants were second-generation immigrants, and two were third generation or beyond. Of these individuals, ethnicities were as follows: Mexican (n=11), Salvadoran (n=3), Puerto Rican (n=1), Nicaraguan (n=1), Colombian (n=1), Venezuelan (n=1), and Tejano (n=1).

Three participants indicated having more than one ethnic identity.

On average, interviews lasted 65 minutes (range 42 to 112 minutes). Participants were forthcoming about their experiences with depressive symptoms and were able to provide rich descriptions of the important events in their lives related to their depressive symptoms. Young adult participants in particular were able to describe their experiences during adolescence with a great deal of insight and perspective. A few participants became tearful during the interview, but most participants remained calm and relaxed. Dr. Stafford followed the interview distress protocol to ensure safety on two occasions; one in which the participant expressed thoughts of self-harm, and one in which there was an abuse concern within the participant's home.

Overview of the Framework

Participants underwent a psychosocial problem that we labeled *Being Overburdened and Becoming Depressed*. Participants responded to this problem through a psychosocial process that we labeled *Getting a Grip on my Depression* (Figure 1). *Getting a Grip on my Depression* is a

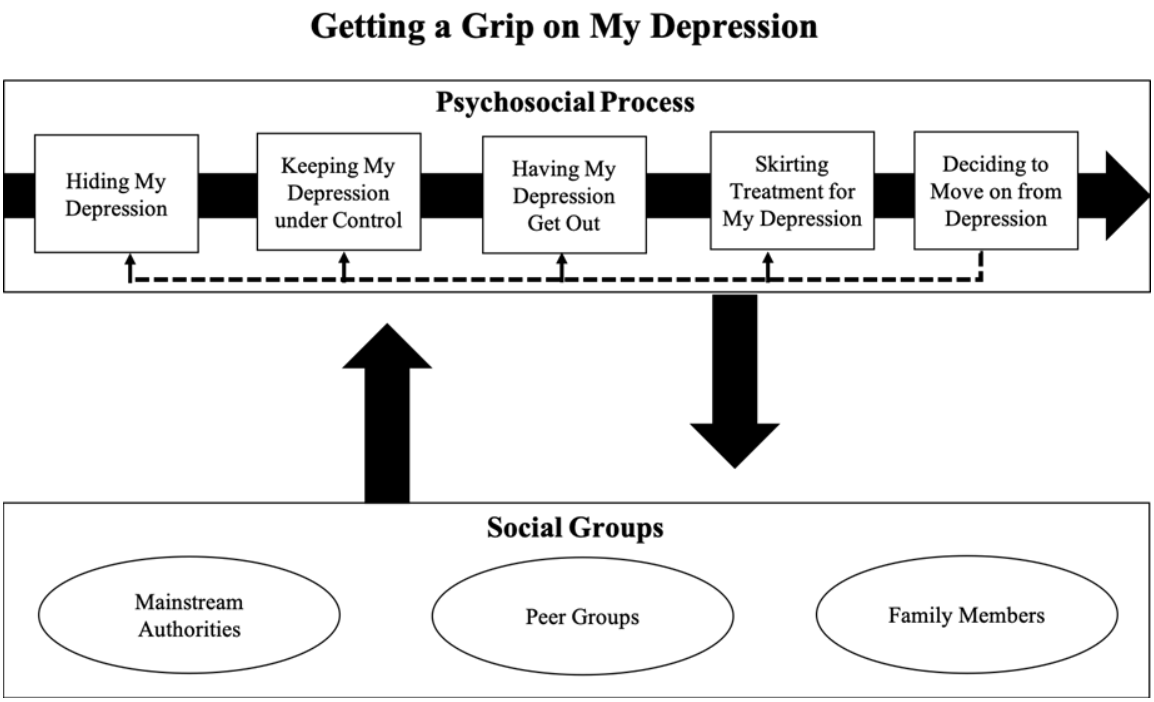

Figure 1. Getting a Grip on My Depression Framework

framework consisting of five phases: 1) *hiding my depression*; 2) *keeping my depression under control*; 3) *having my depression revealed*; 4) *skirting treatment for my depression*; and 5) *deciding to move on from my depression*. Each phase is influenced by three social groups.

The framework is a conceptual rendering of common ways in which the participants discussed *Getting a Grip on my Depression*. However, not every participant experienced all phases in the order they are presented. Some participants experienced a few of the phases, some experienced two phases simultaneously, and some reverted to earlier phases when faced with adversity. For example, a few participants, when having their confidentiality broken by a healthcare provider, reverted to the earlier stage of *keeping my depression under control* without the assistance of a mental health provider. Other participants, upon seeing others' negative reactions when *having my depression revealed*, reverted to *hiding my depression*. The dashed arrows above reflect the possibility that participants, in certain circumstances, can revert to earlier stages. In discussing each phase, the evolving role played by each social group is addressed. Because this framework was based on a sample of 25 participants, we do not claim it is generalizable as a theory to all Latina adolescents, but it does represent a progressive series of stages experienced by adolescents in the sociocultural context described above.

Social Groups

Three social groups figured predominantly in the narratives of the participants and influenced their experiences with depression. Family members included individuals within the participants' nuclear and extended families; participants primarily discussed parents who were also of Latino/a ethnicity. Peer groups included individuals in the participants' schools or local communities such as friends or classmates. Mainstream authorities included adults in healthcare, educational, and government systems, most of whom were white. The role that these groups

played in the participants' experiences of depression evolved over time. Although persons in the three social groups provided help and support for the participants at various points throughout the process, the influences of these groups and the messages they gave to the participants about depression often conflicted, creating additional tension for the participants.

Psychosocial Problem: ***Being Overburdened and Becoming Depressed***

The participants shared a common problem of being overburdened by a variety of stressors that they believed contributed to the development of their depressive symptoms. The participants were stressed because "a lot of things were going on" in their lives, and a variety of stressors "compounded" to contribute to the development of depression. One participant described the weight of all the stressful experiences in her life: "I feel like we're [Latinas] carrying so much more." The stressors that participants experienced often stemmed from their relationships with their family, their peer groups, and mainstream authorities.

Participants felt burdened by family pressures that stemmed from being an adolescent in a family. Because many of the participants' parents immigrated to the US to give their children better economic and educational opportunities, participants experienced much pressure to be the "best of the best" at school, make their family proud, and not let their parents down. Many participants also felt saddled with family responsibilities such as caring for siblings because their parents, often first-generation immigrants, had to work long hours to make ends meet in the US. Participants also experienced conflict with their parents because parents retained traditional values from their home countries that conflicted with norms for adolescent autonomy in the US. As females, some felt that their parents were "overprotective," not allowing them to go out with friends or have boyfriends, and this resulted in the participants feeling frustrated or angry with their parents. Many of the participants in this study also felt deep sadness after being separated

from family members due to economic circumstances, divorce, or deportation.

Many participants discussed stressors in their relationships with peers. While most experienced typical adolescent stressors, such as bullying, some experienced discrimination as Latinas. A few were told by classmates to "go back [to their native country]" or that "[you] don't belong here." Others just felt "weird" or "different" from their non-Latino/a peers.

Participants' interactions with mainstream authorities also contributed to their stress. One of the most pronounced stressors for many participants was the fear of deportation of themselves or their family members due to increased deportation activity in the US after the election of Donald Trump. Participants were "very scared" that they or their family members would be deported. Some also felt hopeless in the face of deportation, wondering what they would do if their parents were "kicked out" of the US. Many participants were burdened with the knowledge that the US was not "good" to minorities and that they would have to be more prepared and work harder than their white peers to get ahead in the US.

Participants connected these multiple stressors to feelings of distress. They often felt sad, upset, or numb in response to events in their lives. Others had "panic attacks" or "explosions" of emotions. In addition to depressive symptoms, many participants engaged in disordered eating and self-harm behaviors. In reflecting on their experiences, participants recognized that these behaviors were manifestations of underlying depression. One participant who suffered from anorexia stated, "Depression was probably the root of it [anorexia], but at the time, like I said, I wasn't aware of any of that." Because participants connected a variety of mental health struggles back to depression, the examples provided below refer to both typical symptoms of depression as well as other mental health challenges such as self-harm, eating disorders, and anxiety. Although participants recognized that these feelings and behaviors were not normal, most did not initially

label their feelings as depression. One participant whose depression was not identified until young adulthood stated, "I just thought I was sensitive. I thought I just cried all of the time. … I never acknowledged the word depression." In response to emerging symptoms of depression, they moved into the psychosocial process labeled *Getting a Grip on My Depression*. While participants spoke about "depression" as a constellation of symptoms such as sadness, numbness, social withdrawal, and lack of motivation, none of the participants used the term "depressive symptoms." For this reason, we refer to "depression" throughout the framework.

Psychosocial Process: *Getting a Grip on My Depression*

Getting a Grip on My Depression represents the core psychosocial process that represented participants' responses to *Being Overburdened and Becoming Depressed*. The common expression getting a grip means taking control of one's emotions or behaviors (Cambridge Dictionary, n.d.). This phrase was chosen because participants attempted to maintain control of their depression through in the context of the social groups in which they were embedded. Participants frequently worked to "get their stuff together" and fought to "handle" their depression as best as they could. The phrase getting a grip also situates the capacity to control one's emotions or behaviors within the individual. The participants in this study most often assumed personal responsibility for controlling their depression rather than seeking help from others. Several participants also expressed ownership of their depression using the phrase "my depression." This phrase also implies an active process. Participants were "figuring out" how to manage their depression and "working" on getting better.

Hiding my depression. We labeled the first phase as *hiding my depression* because the participants initially aimed to keep their depression to themselves. Participants passively kept quiet about the problems they were experiencing and actively took measures to conceal problems

from others. The participants were likely to hide their depression from all social groups.

Family members. Most participants worked hard to ensure that family members, particularly their parents, were not aware of their depression. They attempted to hide their depression due to concerns about how their parents would react to their mental health struggles. In some cases, participants concealed their depression in order not to burden their parents. One participant stated, "I didn't really want to be a burden...We were lower middle class and just something I shouldn't burden with them. …They don't need a daughter who's going insane." Participants knew that their immigrant parents were working tirelessly to provide them with a good life, and they did not want to trouble them with another problem. Other participants received messages from their family that depression was not a "real" problem and feared that parents would be dismissive of their experiences. Participants recognized that their parents, who were often first-generation immigrants, had overcome much adversity to immigrate to the US. Parents would often compare their challenges in immigrating to the US to what they considered to be the minor challenges experienced by their children. One participant remembered her father saying, "You're over here worrying about simple little things. You're sad about simple little things, where people in my country, they don't even have clean water in my country.'" Parents often dismissed participants as being "over dramatic," "making it up," or "wanting attention."

Peer groups. Participants also frequently hid their depression from peers. Many who opened up to friends experienced negative consequences because their friends later betrayed their confidence. One participant stated, "I don't really trust a lot of people because every time I say something to them, they like go and tell other people." Participants learned that they could not trust others and chose to keep their mental health struggles a secret. Some thought that they would disappoint friends if they were to talk about their depression. Other participants did not

want to burden their friends. One participant explained, “Depression is a burden. No one should have to deal with it… It was kind of hard to tell my friends.”

***Mainstream authorities*.** In interactions with mainstream authorities, especially healthcare and school professionals, participants often explicitly lied to conceal their depression. For example, many participants lied when they were given depression screening questionnaires at primary care visits. One participant described such an instance: “I would lie at those question things. I’d be like, ‘Yes, I’m feeling so much better. I feel like I don’t want to cut myself or hurt anyone.’ I’d just lie about it because I didn’t want to be questioned.” Several participants were also approached by teachers or guidance counselors when they noticed something might be wrong with the participants. In these cases, participants also lied to hide their problems. Participants believed that professionals would have to tell their parents about their depression and decided to lie to authorities so word about their depression did not get back to their parents. One participant explained, “I know my friends couldn’t talk to my mom, but if I went and talked to a counselor…I would also sense some sort of risk of it coming back [to mom].”

Keeping my depression under control. We labeled the second phase of *Getting a Grip on My Depression* as *keeping my depression under control* because participants took many measures to “handle” their depression and keep it from spiraling out of control while they were still hiding it from others. Participants used both intra- and interpersonal strategies to keep their depression under control. They participated in activities such as sports, art, dance, and writing as a means to express emotions and “get out of their head." They also found ways to “escape” from their distress by reading, watching TV, or playing games online. Some participants would sleep – or take what one participant called “depression naps” - in order to shut down their brains when their emotions and thoughts were getting out of hand. Some participants attempted to involve

family, peers, and mainstream authorities in their efforts to control their depression.

Family members. While participants most often tried to control their depression on their own, some did make attempts to involve their parents. Unlike the prior phase, participants talked with parents about problems in their lives, such as "drama" with friends or family problems, but they did not frame these problems as depression. In this phase, participants tested their parents' reactions to topics related to mental illness. One participant described an encounter in which her friend, who was also Latina, provided suggestions for talking to parents about depression:

> She said, “Maybe just bring it up someday and see what happens. Don't say, ‘I am depressed.’ Don't say, ‘I think I am depressed.’ Just say, 'Hey, what do you think about depression?’” And so I did that at one point, and that's when they [parents] were saying, "I think sometimes people just make it up for attention."

In some cases, attempts that participants made to control depression were undermined by parents. Some parents inadvertently restricted strategies that participants used to control their depressive symptoms, and participants attributed this to their parents’ traditional values. One participant explained, "That was one of my coping things, listening to music, but they'd [parents] be like, ‘No, no, no, you can't listen to that music in my house. This is a house of God’."

Peer groups. Peers were often involved in participants’ efforts to control their depression. Many participants attempted to control their depression in conjunction with peers who were also experiencing depression. Participants often learned about and were encouraged to participate in self-harm behaviors, especially cutting, by their female peers. One participant explained where she first heard about cutting: "Another girl, she was also depressed. …She just had all of these different thoughts and ideas that she would give me. She’s like, ‘I’m like this, and you should do it too [cutting].'" Others described self-harm as "contagious," "addictive," and "the new style" at

school and used it as a way to relieve their negative feelings. Some participants recognized that while hanging out with friends who were also depressed made them feel better at times, it was not the healthiest way to manage their depression. One participant explained, "My friends in high school had depression too…. Peoples' energies are very contagious, so you have to be a little bit careful to make sure you hang out with some people that don't want to die all of the time." Other participants found "escape" in being with their friends in ways that were not harmful.

***Mainstream authorities*.** Mainstream authorities also played a role in how participants kept their depression under control. Similar to interactions with parents, some participants identified adults from the mainstream authority, such as teachers and pastors, with whom they would talk about their school and family problems. However, like with parents, they did not frame these problems as depression. One participant described her relationship with a youth pastor: "She sort of understands what I was going through. ... I was really struggling with science, and she was majoring in science." As with peers, participants felt that being in the company of adults was a way to distract themselves from their depression. Participants also had coping strategies undermined by mainstream authorities. One participant stated, "I had a poetry club. … I would write super dark stuff in that club. That actually got me sent to a guidance counselor. …I stopped writing depressive stuff at that point because I got omitted from school."

Having my depression revealed. We labeled the third phase of *Getting a Grip on My Depression* as *having my depression revealed* because at some point in time, participants' depression was revealed to others either intentionally or inadvertently. During this phase, important individuals in the participants' lives realized that "something was up." Other participants decided that it was time to reveal their depression when they had "enough of it."

Family members. During this phase, some parents recognized that something was very

concerning about their child's mental health. Many participants were caught by their parents self-harming or attempting suicide, and, at this point, parents realized that they needed to "take action." One participant stated, "I hurt myself, and then I was in the restroom, and then my mom went to the restroom, and I couldn't open the door. She opened, and she saw me…. she took me to the hospital." Other participants were questioned about their mental health when parents noticed extreme changes in the participants' moods. Some participants volunteered information about their depression to parents when they decided it was time to "confront" their depression, but they took care to "tone" down their feelings so as to not alarm their parents. One participant stated, "I didn't tell her [mom] I was suicidal. I was just like, 'Hey, I'm thinking about trying medication. I'm not really feeling too well lately.'"

Peer groups. Some participants revealed their depression to friends who also suffered from depression. One participant stated, "My friend was feeling sad...and so I told her, 'Hey, I feel the same way. I have similar thoughts,' and we just kind of went back and forth, and we talked about what we feel." These participants found it helpful to have peers who appreciated what it was like to have depression. One participant said, "It's good [to have friends with depression] because then you can kind of communicate with people who can understand you."

Mainstream authorities. Many authorities, especially healthcare providers, did eventually learn of the participants' depression. The participants displayed behaviors that exposed their depression, revealed it on an assessment form, or intentionally disclosed it. For example, several providers noticed changes in the participants' weight, signaling underlying mental health concerns. Some participants who had been lying to hide their depression from providers on assessment forms decided that it was time to "tell the truth." One participant described, "In previous years, they did the same screening, and I lied a lot…I kind of hid it for a

really long time, so at that point, I was thinking maybe I should be honest and see what happens." Other participants volunteered concerns about their depression to a healthcare provider directly. One participant stated, "I was telling, because I just need some help. I don't know, how do I bring this up with the doctor? But I ended up telling my doctor about it [depression]."

Skirting treatment for my depression. We labeled the fourth phase as *skirting treatment for my depression* because while many participants did receive some form of mental health treatment, they typically used services inconsistently. Participants commonly skirted treatment by initiating mental health services and then abruptly discontinuing them due to a variety of reasons. Some participants would begin this process over again with a different mental health provider. One participant described this situation: "Could I actually get help? Every time I would get close to help in some way, shape, or form, it got either messed up or cut off."

Family members. The family played a large role in the participants' skirting of mental health treatment. Many participants perceived their parents as not valuing mental health treatment and attributed this to stigma towards depression in the Latino/a culture. Some participants' parents were resistant to their children receiving any mental health services, whereas others were skeptical of medication but thought that talking with a therapist was acceptable. Once participants were involved in mental health treatment, parents often did not encourage continuing treatment. One participant stated, "So she [mom] used to make my [therapist] appointments for me, and then it's been about two months where I didn't go, and then I was like, 'What's going on?' 'Oh, no, you're fine now.'…I was not feeling fine."

Peer groups. Peers were usually not very influential in participants' receipt of treatment for depression. In a few instances, some friends encouraged treatment, but others discouraged it, thus contributing to the skirting of treatment for depression. The following story reflects how a

participant received conflicting messages from her friends about the value of treatment:

> I had two best friends at the time – A and K. I called A and I was like, "Hey, I'm in the hospital, and they're about to send me to the psych ward, and I don't know how to get out of here." …She was like, "You probably need to be there. Just tell them the truth. You need to get some help. It'll be okay." …Then I called K, and she was like, "You need to get the fuck out. Don't tell them anything. They never listen to you."

Mainstream authorities. Mainstream authorities, healthcare providers in particular, had many missed opportunities to engage or maintain youth in mental health treatment. Participants discontinued treatment for a variety of reasons, mainly because they objected to some aspect of it. Some felt "crazy" or like a "psychopath" because they had to see a mental health provider. Others disliked their therapist or therapy itself, referring to it with words like "sketchy" or "nonsense-based." Participants thought that healthcare providers were "throwing" antidepressants at them, which left them feeling "blank" and "zoned out." Many participants were concerned about a therapist revealing information to their parents. One participant said, "She [therapist] was forced to tell my parents that I was having issues…what's the point in seeking help when I'm still a minor, and no matter who I go to they have to report it to my parents?" Some participants stopped their treatment abruptly while others told their therapists what they wanted to hear in order to be released from treatment. One participant who was hospitalized for suicidal ideation explained, "I talked to this doctor, and he's the one who determined if we were going to go home or if we had to stay longer. Most of us lied." Some participants had interactions with guidance counselors at school in relation to their mental health problems, but these encounters did not have a significant impact on the trajectory of the participants' depression. One participant explained, "She [guidance counselor] would ask me if I

was okay…So she kind of like checked in, but it wasn't anything really substantial."

Deciding to move on from depression. We labeled the fifth phase as *deciding to move on from depression* because many participants made decisions to take matters into their own hands and leave depression in the past. This phase thus reflects how participants independently adopted a more positive perspective or abandoned stressful life circumstances. Participants told themselves "it was time to change," decided to start a new "chapter," and "got [their] stuff together." Others found a more positive outlook on life. One participant described her response to hearing a song in church: "In that song, it said that I could go through these hard things, so I decided that Him telling me I can go through this, that's when I decided to think more positive than the usual." Some participants made changes in their academic or living situations once they reached young adulthood. One participant stated, "The change from high school to college honestly saved my life. I could not have done another however many years of high school ever." Social groups played minimal roles in this phase, and participants primarily attributed their recovery to their own determination or growth. One participant stated, "I've done the best job of dealing with my mental health than anyone else has. No doctor or mental professional has really provided me any sort of assistance that's helped me out. …I've really had to help myself."

Family members. Participants did not describe their families as being very influential in moving on from depression. A few parents came to realize that the participants' depression was a serious problem and were allies in their recovery. After being hospitalized for suicidal ideation, one participant described, "They've [parents] been more understanding. …There's just been a lot of encouragement after that too. 'Yes, you're going to get better. We're going to help you.'"

Peer groups. Similar to parents, peers did not play a major role in participants' leaving depression behind, however, some did have friends who prompted changes in the participants'

life perspectives. One participant described, "I remember he [friend] asked me why I stopped trying. ...Those words stayed stuck in my head. I was like, 'Why stop trying? Why give up now?' So that's when I started improving, and it was just those words." Others discovered that their friends were supportive of their progress when they decided to reveal their depression to them.

Mainstream authorities. Mainstream authorities also played a minimal part in most participants' moving on from depression, although a few participants had mental health providers who cared about them and facilitated their efforts to overcome depression. Some described how they began to consider advice from their therapists and tried coping strategies that their therapists had suggested. One participant explained, "I did what they [therapists] told me to do. I started finding things, good hobbies. …Why didn't I listen to them when I was in therapy?"

Discussion

The Latina participants in this study described complex processes through which they experienced, self-managed, and sought treatment for depressive symptoms. The development of their depressive symptoms was closely tied to a variety of stressors, some of which were attributable to typical adolescent development and some of which were attributable to cultural stressors. What was most notable about their response to their depressive symptoms *(Getting a Grip on My Depression)* was that despite close ties to families and peers, as well as interactions with mainstream authorities, their response to depressive symptoms was largely intrapersonal. Initially, they kept their depression to themselves (*hiding my depression*) and coped with it largely on their own (*keeping my depression under control*). When the depression did become known (*having my depression revealed*), it was primarily because accompanying mental health problems, such as self-harm, became obvious to others. Most participants never became engaged in a therapeutic relationship (*skirting treatment for my depression*) and ultimately assumed

responsibility for their own well-being. This often occurred after insight that it was up to them to leave depression behind and move on with their lives (*moving on from depression*).

Some of the findings from this study resonate with previous research on the mental health of adolescents in general and of Latino/a adolescents more specifically. For example, the problem identified as *Being Overburdened and Becoming Depressed* is consistent with the findings of previous studies that have described links between discrimination, family pressures and conflicts, fears of deportation or separation, and mental health concerns in Latino/a adolescents (Garcia & Lindgren, 2009; Lopez-Morales, 2008; McCord et al., 2018; Roche, Vaquera, white, & Rivera, 2018). Consistent with the phase *hiding my depression*, several studies have shown that Latino/a, non-Latino/a black, and non-Latino/a white adolescents initially choose to hide mental health problems from others due to fear of being judged (Al-Khattab, Oruche, Perkins, & Cordel et al., 2016; Draucker, 2005a; Gulbas & Zayas, 2015; Lopez-Morales, 2008; Olcoń & Gulbas, 2018). Similar to the *taking control of my depression* phase, a study of depression among black adolescents revealed that participation in sports and clubs; spending time with friends who also had mental health problems; and listening to music as a means to manage their depressive symptoms was helpful (Al-Khattab, 2016). Other studies have also found that adolescents who are depressed are drawn to peers who are depressed (Kiuru, Burk, Laursen, Nurmi, & Salmela-Aro, 2012; van Zalk, Kerr, Branje, Stattin, & Meeus, 2010). Adolescents in prior studies also described a variety of ways of having their depression revealed, such as voluntarily disclosing their depressive symptoms (Al-Khattab et al., 2016), hinting at their depression to see how adults would react (Draucker, 2005a), and being confronted about their mental health by adults in their lives (Al-Khattab et al., 2016), similar to what was described by Latina adolescents in the current study. Participants' *skirting treatment for*

depression has also been described in prior research with adolescents reporting numerous pitfalls to receiving mental health services, such as being labeled as "crazy," being "pumped" with medication, fearing violations of confidentiality, and feeling misunderstood by the therapist (Draucker, 2005b; Schneider, 2017).

While some aspects of the process by which Latina adolescents manage their depression have been noted in previous research on diverse adolescent populations, our findings extend this body of research in several ways. Although other studies have linked cultural stressors such as discrimination and family conflicts related to culture to depressive symptoms among Latina adolescents, our study was the first to use the participants' own narratives to develop a framework that depicts the complex and dynamic processes by which these factors influenced their depression over time. Studies also demonstrate that adolescents hide their depression from adults; however, the Latina participants in this study went to particular lengths to hide their depression, including lying outright to primary care providers. Participants were especially invested in keeping their depression from their parents and related this to their Latina heritage and unique challenges associated with being first- or second-generation immigrants. Another finding that has not been well described in the literature was that many participants experienced a distinct turning point when they decided to move on from depression and largely attributed their recovery from depression to their own insight and resilience. Finally, the framework captures complexity that has not been evident in previous research in that the influence of each of the three social groups on each phase in the framework is delineated. This framework is also the first to contextualize a multi-phase process by which Latina adolescents respond to depressive symptoms in the context of the social groups in which they are embedded.

The findings should be considered within the context of the limitations of the study.

Young women who identify as Hispanic or Latina were the focus of this study. Hispanic and Latina are terms that describe individuals from many diverse backgrounds. Variations in these cultural backgrounds, such as generational status, level of acculturation, skin tone, and specific cultural values, may impact Latina adolescents' experiences with the development of, self-management of, or treatment-seeking for depressive symptoms. These cultural variations are not captured and accounted for by broadly recruiting Latinas. Therefore, we are not able to make conclusions about how Latinas of varying sub-groups experience depressive symptoms, and clinicians and researchers should not assume that the framework presented in this article represents the experience of every Latina adolescent with depressive symptoms. The study is also limited by its inclusion of only Latinas who were fluent in English, perhaps excluding those who may be more recent immigrants to the US and face different challenges than the participants in this study. Additionally, the cross-sectional approach only allowed us to gather data about participants' experiences with depressive symptoms at one point in time. Young adults were included so that they could reflect on how their experiences with depressive symptoms evolved over time; however, these young adults may have experienced difficulties in recalling information due to the passage of time. The use of self-report of depressive symptoms is also a limitation. While all participants reported having depressive symptoms as adolescents, and some had received a formal diagnosis of depression, we could not determine if some participants experienced sub-syndromal symptoms of depression or would have met diagnostic criteria for a depressive disorder. A retrospective diagnostic interview would have allowed us to explore how the severity, intensity, and duration of the depression affected the process of *Getting a Grip on My Depression*.

A longitudinal study that would allow for a series of interviews with Latino/a adolescents

and young adults that could capture nuanced changes in their experiences with depression over time would further refine the framework presented in this article. Such a study should be conducted with a larger and more diverse sample, including Latino young men and individuals of varying Latino/a backgrounds and immigration statuses. This would allow examination of group differences on symptom experiences and treatment pathways. As there appear to be many similarities in the process by which Latina and other groups of adolescents manage depression, it may also be useful to determine which aspects of this process appear to be unique to the Latina adolescent's experience and which may be common to other groups of adolescents (ex. lying to providers to hide depression). Due to the influential role that the family played in the adolescents' experiences with depressive symptoms, further research might also include interviews with family members to obtain their perspectives on the stressors faced by their adolescents and their points-of-view about depression and mental health services.

Because several aspects of the process by which Latina adolescents manage and seek treatment for their depressive symptoms have not been noted in other groups of adolescents, healthcare providers should take unique approaches when identifying and treating depression in this population (Hooper et al., 2016). The framework developed in this study can be used as a guide to springboard discussions with Latina adolescents about their mental health. Healthcare providers might pose questions to Latina adolescents based on the phases identified in the framework. For instance, one question that a provider might ask based on this framework is, "Some Latina teens hide their feelings of depression because they fear how their parents will react if they find out they are depressed. Is this something that you have worried about?" Questions such as these may assist providers in identifying Latina adolescents that are in the phase of hiding their depression. If the provider has determined that the adolescent is

experiencing depressive symptoms, they might state, “Some Latina teens who feel depressed have friends who are also depressed. Do you have other friends who are going through similar mental health struggles?” The response to this question may assist providers in determining if adolescents are involved in friend groups that may be promoting self-harm. Practitioners should also consider ways to educate parents of Latina adolescents about the cultural stressors they face and teach parents how to discuss these stressors with their children.

Our findings reinforce the importance of confidential consultations between adolescent patients and primary care providers. Studies have demonstrated that adolescent patients are more likely to discuss mental health concerns with primary care providers when parents are not present in the room (Gilbert, Rickert, & Aalsma, 2014; Lewis Gilbert et al., 2018). Latina adolescents may be less likely to hide or lie about their depression if primary care providers have private conversations with these patients. Primary care providers should also be aware that they are not obligated to report the adolescent’s depression to the parents if the adolescent is not in danger of hurting themselves or others (Shain & AAP Committee on Adolescence, 2016). If it is necessary to disclose the adolescent’s depression to parents, the provider should be transparent about the process and allow the adolescent to have as much control over the conversation as is appropriate.

Many participants saw a mental health provider at one point in time but were turned off from mental health services because they were not able to make a connection with the therapist or disliked the treatment approach. At the beginning of the therapy process, mental health providers should assess adolescent and family beliefs about depression and how those beliefs might influence treatment engagement. Mental health providers can also incorporate Latino/a cultural values such as *familismo* (family closeness), *personalismo* (personal relationships), and *respeto* (respect) into evidence-based treatments (Davidson et al., 2015). Mental health providers

might also consider involving the family in some components of the adolescents' therapy to address family stressors contributing to depression. The framework can also be used as a springboard to initiate discussions about how Latina adolescents are responding to their depression and how social groups may be impacting recovery.

Conclusion

We developed a framework that describes the process by which Latina adolescents experience, self-manage, and seek treatment for their depressive symptoms. Similar to other adolescents, Latina adolescents hide their depression from others, engage in activities to distract themselves from their depression, and perceive many downsides to receiving mental health services. What has not been observed in previous studies of adolescent depression management is that the Latina adolescent's experience with depression was largely intrapersonal. Despite the influences of the family, peer groups, and mainstream authorities, Latina adolescents went to great lengths to keep other individuals from knowing about and intervening with their depression and primarily moved on from depression on their own. Future research is needed to enhance the framework and explicate how the process of *Getting a Grip on My Depression* might vary across different groups of Latino/a adolescents. Healthcare providers can use the framework to broach mental health topics with Latina adolescents to more effectively identify those struggling with depressive symptoms, promote engagement in mental health treatment, and ultimately, improve their mental health outcomes.

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[i] Data referring to racial/ethnic mental health disparities were taken from the Youth Risk Behavior Survey (CDC, 2018) and the National Survey on Drug Use and Health (SAMHSA, 2017). In these surveys, racial groups are classified as non-Latino/a "white," non-Latino/a "black," and Latino/a. So as to not misrepresent the data and remain consistent with terminology, we use the terms non-Latino/a white, non-Latino/a black, and Latino/a to refer to racial/ethnic categories throughout the article.